PATIENT INFORMATION AND CONSENT FORM

NITROUS OXIDE

I consent to Dr. _____ and/or their chosen assistants using nitrous oxide sedation. Nitrous oxide sedation can help with anxiety, pain, and gagging as well as people who are medically compromised.

I understand that medicine and conscious sedation with nitrous oxide have potential hazards, risks, and unpleasant side effects. These are infrequent but could happen. They include:

1. **Excessive perspiration:** I may sweat during the procedure and get a little flushed while getting nitrous oxide.
2. **Expectoration:** The dentist can use a suction tip to try to get rid of extra saliva.
3. **Behavioral problems:** I may become difficult to treat because I am so talkative or have vivid dreams that make me move my body.
4. **Shivering:** Although not common, shivering can be uncomfortable. Patients usually shiver at the end of the sedative procedure when the nitrous oxide has been ended.
5. **Nausea and vomiting:** This is the most common side effect of nitrous oxide sedation, but the risk is still low. It is important to tell the dentist, hygienist, or assistant if I feel nauseous. The dentist can manage this side effect by changing the level of nitrous oxide.
6. **Driving a motor vehicle:** I may not feel comfortable driving after nitrous oxide. If this happens, I can wait in the clinic until I feel better, or staff can call a friend or cab to safely get me home.

I understand my other options along with their benefits and risks. Risks include fear and anxiety of the dental experience and/or avoiding future dental appointments. These fears and anxiety, if not diminished using nitrous oxide sedation, may cause other medical problems, including fainting, palpitation, and other heart-related disorders.

I understand my consent for this procedure and its risks. I understand that dentistry is not an exact science. I acknowledge that every effort will be made in my behalf for a positive outcome from sedation, but the dentist has not promised me any specific results because of this procedure.

_____ _____

Patient's name (please print) Tooth No.(s)

_____ _____

Signature of patient, legal guardian, or authorized representative Witness to signature

_____

Date

_____

Date